

CONFIDENTIAL per 34 CFR 361.49

DIVISION OF DISABILITY, AGING AND REHABILITATIVE SREVICES

Bureau of Developmental Disabilities Services Vocational Rehabilitation Services

*Your Social Security number is being requested by this state agency Per IC 4-1-8-1. Disclosure is mandatory and this form cannot be completed without it.

		PART 1 – REI	ERRAL INF	ORMA	TION					
Name (last, first, middle, maiden)					Date of referral (mo., day, yr.)			no., day, yr.)		
Address (street and number, city, state)					County		ZIP code			
*Social Security number	Date of birth	f birth (mo., day, yr.) Sex			Telephone number					
Disability / diagnosis			Male		Female					
Referral source		Telephone num	ber		If deaf or no		speakin Yes	g, is an inter	preter needed No	
Does the applicant have a driver's license?) C:	an the a	pplicant use publi					
	Yes	☐ No		arr erro er	pprount ase pass]	Yes	3	☐ No	
in accomplishing the goals of the in	No. Frederical Co.	avw it will impact	on the family.							
Name of Doctors / Hospitals Familiar With Applicant Disability / Diagnosis		Address of Doctors /			Hospitals			Date and Type of Last Exam		
Describe any medical attention the app	olicant is now	receiving / has rec	eived (include	medici	nes, therapies, and	d counseli	ng)			
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Name one (1) person who will know the applicant's address in the event of a move.													
Name and Relationship	Addre	ess (street and n	umber, city, state)		Telephone Number								
			(
List schools the applicant has attended be	ginning with the mos	st recent (High S	Type of Training		II: -1 4 C	1-							
Name of School	City and	State	Degree / Certificate		Highest Grade Completed and Year								
Nume of School	City and	State	Degree / Certificate		Completed and Tear								
List jobs the applicant has had beginning with the most recent. (attach additional sheet if necessary)													
Name of Employer,		(cirraeri addiri	The street is necessary)		Empl	mployent							
City and State	Job Title	Wages	Reason for Leavi	ng	From	То							
1.													
2.													
3.													
4.													
List work tasks on the jobs identified about 1.	ve.												
1.													
2.													
3.													
3.													
4.													
T. 1.199.2		1 1	1 . 1 . 1 .										
List rehabilitation programs or other agen				ning with t	Kinds of Serv	ioos							
Facility or Agency's Name and Address (street and number, city) Date Kinds of S													
			l	I.									
I have been informed that al information of													
and social condition by the Division of Di													
authorized to help in my habilitation / reh													
agencies. I have received written information concerning my right to appeal certain decisions made by these agencies and their contractors or vendors and the procedures to be followed in making such an appeal. I hereby apply for services from (check one or both) \sum Vocational													
Rehabilitation Services Bureau of Developmental Disabilities Services.													
Signature of applicant / parent / guardian	Date	Date signed (mo., day, yr.)											
I acknowledge the receipt of Notification of Parent / Client Rights and the opportunity to have these rights explained to me. (for BDDS applicants)													
Signature of parent / guardian or advocate Date signed (1)						yr.)							